NOTIFICATION OF PREDESIGNATION OF PERSONAL PHYSICIAN

In the event you sustain an injury or illness related to your employment, you may be treated by your personal medical doctor if:

- your employer offers group health coverage
- the doctor is your regular physician, who shall either be a physician who has limited his or her practice of medicine to general practice or who is board-certified or board eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner and has previously directed your medical treatment, and retains your medical records;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries;
- prior to the injury, your doctor agrees to treat you for work injuries or illnesses;
- prior to the injury, you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work related injury or illness, and (2) your personal doctor's name and business address.

This shall serve as my notification to the City of San Diego that in the event of a work related injury or illness; I wish to be treated by my primary care physician.

PHYSICIAN____________________________**SPECIALTY**____

ADDRESS____
Street **City** **Zip Code**

PHONE_________________________________

I understand this completed form will be retained by Risk Management for referral in the event of a work-related injury or illness. I further understand that this form must be on file prior to any work-related injury or illness in order for me to be treated by my physician.

EMPLOYEE_____________________________________

SOCIAL SECURITY #____________________________

DEPARTMENT_________________________________ **SUPERVISOR**______________________________

____ ______________________________________
EMPLOYEE SIGNATURE **DATE**

*****IMPORTANT INSTRUCTIONS*****

1. Complete and sign this page of the form
2. Have your physician sign and date the other side of this form.
3. Return the form to Risk Management at either:
   MS 51 B or
   P.O. Box 129013 San Diego CA 92112-9013

PERSONAL PHYSICIAN DESIGNATION CERTIFICATION

I UNDERSTAND that my patient has selected me as his/her pre-designated physician for work related injuries and illnesses.

I HEREBY CERTIFY THE FOLLOWING:

1. I am the patient's **primary care physician** and I have previously directed the patient's medical treatment.
2. I have the patient's medical records.
3. I agree to the pre-designation.

______________________________ ______________________________

PHYSICIAN SIGNATURE/SPECIALTY **DATE**

As the pre-designated treating physician, you must agree to comply with the Reporting Duties of the Primary Treating Physician as contained in Title 8 of the California Code of Regulations, Section 9785.

Further, **all treatment plans must be pre-approved by the City of San Diego's mandatory utilization review program.** Treatment will be peer review and authorized in accordance with the American College of Occupational and Environmental Medicine practice guidelines. Payments will be authorized in accord with pre-authorized treatment and the Official Medical Fee Schedule as adopted pursuant to California Labor Code section 5307.1.